

SECOND REGULAR SESSION

# HOUSE BILL NO. 1446

## 91ST GENERAL ASSEMBLY

---

INTRODUCED BY REPRESENTATIVE LUETKENHAUS.

Read 1<sup>st</sup> time January 14, 2002, and 1000 copies ordered printed.

TED WEDEL, Chief Clerk

3698L.011

---

### AN ACT

To repeal section 376.1350, RSMo, and to enact in lieu thereof one new section relating to exclusions from certain insurance definitions.

---

*Be it enacted by the General Assembly of the state of Missouri, as follows:*

Section A. Section 376.1350, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1350, to read as follows:

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

- (1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;
- (2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;
- (3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;
- (4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;
- (5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as

- 19 typically manages the medical condition, procedure or treatment under review;
- 20 (6) "Clinical review criteria", the written screening procedures, decision abstracts,
- 21 clinical protocols and practice guidelines used by the health carrier to determine the necessity
- 22 and appropriateness of health care services;
- 23 (7) "Concurrent review", utilization review conducted during a patient's hospital stay or
- 24 course of treatment;
- 25 (8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under
- 26 the terms of a health benefit plan;
- 27 (9) "Director", the director of the department of insurance;
- 28 (10) "Discharge planning", the formal process for determining, prior to discharge from
- 29 a facility, the coordination and management of the care that a patient receives following
- 30 discharge from a facility;
- 31 (11) "Drug", any substance prescribed by a licensed health care provider acting within
- 32 the scope of the provider's license and that is intended for use in the diagnosis, mitigation,
- 33 treatment or prevention of disease. The term includes only those substances that are approved
- 34 by the FDA for at least one indication;
- 35 (12) "Emergency medical condition", the sudden and, at the time, unexpected onset of
- 36 a health condition that manifests itself by symptoms of sufficient severity that would lead a
- 37 prudent lay person, possessing an average knowledge of medicine and health, to believe that
- 38 immediate medical care is required, which may include, but shall not be limited to:
- 39 (a) Placing the person's health in significant jeopardy;
- 40 (b) Serious impairment to a bodily function;
- 41 (c) Serious dysfunction of any bodily organ or part;
- 42 (d) Inadequately controlled pain; or
- 43 (e) With respect to a pregnant woman who is having contractions:
- 44 a. That there is inadequate time to effect a safe transfer to another hospital before
- 45 delivery; or
- 46 b. That transfer to another hospital may pose a threat to the health or safety of the woman
- 47 or unborn child;
- 48 (13) "Emergency service", a health care item or service furnished or required to evaluate
- 49 and treat an emergency medical condition, which may include, but shall not be limited to, health
- 50 care services that are provided in a licensed hospital's emergency facility by an appropriate
- 51 provider;
- 52 (14) "Enrollee", a policyholder, subscriber, covered person or other individual
- 53 participating in a health benefit plan;
- 54 (15) "FDA", the federal Food and Drug Administration;

55 (16) "Facility", an institution providing health care services or a health care setting,  
56 including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical  
57 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory  
58 and imaging centers, and rehabilitation and other therapeutic health settings;

59 (17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding  
60 the:

61 (a) Availability, delivery or quality of health care services, including a complaint  
62 regarding an adverse determination made pursuant to utilization review;

63 (b) Claims payment, handling or reimbursement for health care services; or

64 (c) Matters pertaining to the contractual relationship between an enrollee and a health  
65 carrier;

66 (18) "Health benefit plan", a policy, contract, certificate or agreement entered into,  
67 offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of  
68 the costs of health care services; **except that, health benefit plan shall not include any**  
69 **coverage pursuant to liability insurance policy, workers' compensation insurance policy,**  
70 **or medical payments insurance issued as a supplement to a liability policy;**

71 (19) "Health care professional", a physician or other health care practitioner licensed,  
72 accredited or certified by the state of Missouri to perform specified health services consistent  
73 with state law;

74 (20) "Health care provider" or "provider", a health care professional or a facility;

75 (21) "Health care service", a service for the diagnosis, prevention, treatment, cure or  
76 relief of a health condition, illness, injury or disease;

77 (22) "Health carrier", an entity subject to the insurance laws and regulations of this state  
78 that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of  
79 the costs of health care services, including a sickness and accident insurance company, a health  
80 maintenance organization, a nonprofit hospital and health service corporation, or any other entity  
81 providing a plan of health insurance, health benefits or health services; **except that such plan**  
82 **shall not include any coverage pursuant to a liability insurance policy, workers'**  
83 **compensation insurance policy, or medical payments insurance issued as a supplement to**  
84 **a liability policy;**

85 (23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

86 (24) "Managed care plan", a health benefit plan that either requires an enrollee to use,  
87 or creates incentives, including financial incentives, for an enrollee to use, health care providers  
88 managed, owned, under contract with or employed by the health carrier;

89 (25) "Participating provider", a provider who, under a contract with the health carrier or  
90 with its contractor or subcontractor, has agreed to provide health care services to enrollees with

91 an expectation of receiving payment, other than coinsurance, co-payments or deductibles,  
92 directly or indirectly from the health carrier;

93 (26) "Peer-reviewed medical literature", a published scientific study in a journal or other  
94 publication in which original manuscripts have been published only after having been critically  
95 reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and  
96 that has been determined by the International Committee of Medical Journal Editors to have met  
97 the uniform requirements for manuscripts submitted to biomedical journals or is published in a  
98 journal specified by the United States Department of Health and Human Services pursuant to  
99 section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed  
100 medical literature. Peer-reviewed medical literature shall not include publications or  
101 supplements to publications that are sponsored to a significant extent by a pharmaceutical  
102 manufacturing company or health carrier;

103 (27) "Person", an individual, a corporation, a partnership, an association, a joint venture,  
104 a joint stock company, a trust, an unincorporated organization, any similar entity or any  
105 combination of the foregoing;

106 (28) "Prospective review", utilization review conducted prior to an admission or a course  
107 of treatment;

108 (29) "Retrospective review", utilization review of medical necessity that is conducted  
109 after services have been provided to a patient, but does not include the review of a claim that is  
110 limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding  
111 or adjudication for payment;

112 (30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by  
113 a provider other than the one originally making a recommendation for a proposed health service  
114 to assess the clinical necessity and appropriateness of the initial proposed health service;

115 (31) "Stabilize", with respect to an emergency medical condition, that no material  
116 deterioration of the condition is likely to result or occur before an individual may be transferred;

117 (32) "Standard reference compendia":

118 (a) The American Hospital Formulary Service-Drug Information; or

119 (b) The United States Pharmacopoeia-Drug Information;

120 (33) "Utilization review", a set of formal techniques designed to monitor the use of, or  
121 evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,  
122 procedures, or settings. Techniques may include ambulatory review, prospective review, second  
123 opinion, certification, concurrent review, case management, discharge planning or retrospective  
124 review. Utilization review shall not include elective requests for clarification of coverage;

125 (34) "Utilization review organization", a utilization review agent as defined in section  
126 374.500, RSMo.